RI MEDICAL ASSISTANCE PROGRAM

PHARMACY CLAIM FORM

PLEASE TYPE OR PRINT CLEARLY. ONLY **BLACK** OR **BLUE** INK CAN BE PROCESSED.

LINE	RECIPIENT LAST NAME / RECIPIENT ID NUMBER	FIRST NAME	LOC CODE	EPSDT	OI IND	OI CARR.	COMPOUND	PRESCRIPTION NUMBER / PRESCRIBING PHYSICIAN NO.	DATE DISPENSED / NATIONAL DRUG CODE (NDC) DISPENSED	ALLOWED REF	REFILL CODE	DAW	METRIC QUANTITY	DAYS SUPPLY	USUAL & CUSTOMARY CHG.	DISP. FEE	OI AMOUNT	CHARGE (INCLUDE DISPENSING FEE)
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		

INTERNAL CONTROL NUMBER MEDICAL ASSISTANCE USE ONLY

COMPOUNDS

PROVIDER NAME _____

PROVIDER NUMBER:

TOTAL UCR | TOTAL OI | TOTAL CHARGE

RETURN ORIGINAL TO:

PHARMACY CLAIMS
ELECTRONIC DATA SYSTEMS
P.O. BOX 2005
WARWICK, RI 02887

PHARMACY CERTIFICATION

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

PROVIDER SIGNATURE _____ DATE _____

EDS COPY